DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Huachuca, Arizona 85613-7040

MEDDAC MEMORANDUM 29 October 2004
NO. 40-163

MEDICAL SERVICES
Pain Management

1. HISTORY: This issue publishes a revision to this publication.

2. PURPOSE: It is the policy of this organization to respect and support the patient’s right to optimal pain assessment, management, and education. At some point along the continuum of care, a screen for pain occurs in all patients in our organization. When warranted by the screen, patients undergo a comprehensive pain assessment by our providers.

3. SCOPE: Pain management involves the efforts all clinical staff members assigned to Raymond W. Bliss Army Health Center (RWBAHC) who has have contact with patients.

4. REFERENCES:

4.1 JCAHO Comprehensive Accreditation Manual for Ambulatory Care, current edition

4.2 Raymond W. Bliss Army Health Center Web site

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***** This memorandum supersedes MEDDAC MEMO 40-163, dated 25Jun04.

6. RESPONSIBILITIES:

6.1 The Deputy Commander for Clinical Services (DCCS) will:

6.1.1 Serve as the proponent for this memo and ensure that the standards defined in this memo are enforced in all patient care areas.

6.1.2 Provide education on pain management to all clinical staff on an annual basis.

6.2 The Deputy Commander for Health Services will provide initial and annual competency based assessment of all clinical support staff and assist the DCCS and Department/Service chiefs in the enforcement of pain management standards in all patient care areas.

6.3 Department/Service Chiefs will:

6.3.1 Ensure department/service staff comply with the standards defined in this memo.

6.3.2 Ensure copies of patient Bill of Rights, which states that all patients have the right to appropriate pain management, is prominently displayed in the clinics.

6.4 Licensed Independent Practitioners(LIP) will:

6.4.1 Perform comprehensive assessments of patients with pain when indicated.

6.4.2 Prescribe appropriate analgesics and/or adjuvants.

6.4.3 Document assessment/findings/education in the patient's chart.

6.4.4 Consult other services within the organization as necessary to facilitate a multi-disciplinary approach to pain management.

6.4.5 Refer patient to another medical treatment facility when the complexity of a patient’s pain management exceeds individual expertise or involves modalities not available at RWBACH.

6.5 Registered or Licensed Practical Nurses will:

6.5.1 Ensure that Medics (91W)/Certified Nursing Assistants under their supervision apply and document age-specific pain screening criteria when warranted by the chief complaint.

6.5.2 Administer medications as prescribed by providers in accordance with MEDDAC Policy.

6.5.3 Educate patient/family members at the site of care about pain management.

6.6 Medics (91W)/Certified Nursing Assistants will:

6.6.1 Apply and document age-specific pain screening criteria when warranted by the chief complaint.

6.7 The pharmacy staff will verify that any patient receiving an analgesic prescription has been given appropriate written information regarding their medication – to include side effects and any food/drug interactions.

7. PAIN MANAGEMENT PHILOSOPHY. The organization recognizes that pain is an extremely subjective experience and as such, the patient is the best judge of the intensity of pain. If the patient is unable to report, other methods to assess pain include: (1) Family or others close to the patient reports of pain; (2) Patient behavior; and (3) Physiological parameters.

8. SCREENING. The organization conducts pain screening in a uniform fashion by using standardized tools. A standard pain screen for the presence, intensity, location, and duration of pain is documented on the top portion of the SF Form 600 Chronological Record of Medical Care (see Appendix A). Details concerning how the organization screens for pain intensity are covered at Appendix B.

8.1.1 All clinics residing in the Department of Primary Care and the Department of Military Medicine, and the Department of Behavioral Health will screen patients for pain at the first visit after in-processing, and thereafter when warranted by the chief complaint.

8.1.2 In the Optometry, General Surgery, Orthopedics, General Surgery, Urology, and Gynecology clinics; the Internal Medicine

Service; and the Department of Preventative Medicine clinics - pain screens are performed when warranted by the chief complaint.

8.1.3 In the Physical Therapy clinic, pain screens are not conducted, but a comprehensive pain assessment is conducted on all patients at the initial assessment – and thereafter upon reassessment, when warranted by the chief complaint (see below for description of a pain assessment).

8.1.4 In the Department of Ancillary Services, a verbal screen for pain will be conducted when warranted by the procedure, such as when performing phlebotomy, establishing intravenous access for pyelograms, or positioning a patient for a diagnostic study.

8.1.5 The Department of Anesthesia & Perioperative Services will screen all patients for pain at multiple steps along the continuum of care. As mentioned above under SCREENING, prior to surgery, a preadmission nurse conducts a pain screen on MEDCOM FORM 686-R during the initial preoperative assessment (see Appendix C). On the day of surgery, the operating room nurse, anesthesia provider, and the Post Anesthesia Care Unit (PACU) nurse will conduct a baseline pain screen on all surgical patients.

9. ASSESSMENT: A positive screen for pain triggers a comprehensive assessment in the patient care area where the screen occurs. LIPs will perform these assessments. An adequate assessment includes a deliberate and well-documented description of one or more of the following parameters:

9.1 Clarification of intensity

9.2 Clarification of location

8.3 Clarification of duration

9.4 Characteristics/quality (aching, burning, shooting, etc.)

9.5 Time of onset

9.6 Aggravating/alleviating factors

9.7 Associated signs/symptoms

9.8 Impact on functional ability

9.9 Methods of pain management that have – or have not - been helpful or not in the past.

10. PAIN MANAGEMENT:

10.1 Licensed Independent Practitioners (LIPS) working in the Department of Primary Care and the Department of Military Medicine clinics perform limited pain management in patients with straightforward pain conditions. Modalities used include the administration or prescribing of analgesics/adjutants, the application of ice packs, soft tissue steroid injections, or the splinting of fractures.

10.2 LIPS working the Department of Behavioral Health clinics may perform or assist with limited management of pain in patients with straightforward pain conditions – especially when the pain symptom has a major psychological component. Modalities used include the administration or prescribing of analgesics or adjutants.

10.3 The extent of pain management performed in the Department of Specialty Care depends on the site of care. The Optometry clinic uses standard ophthalmologic modalities such as patching and topical analgesics when warranted. Providers in General Surgery, Urology, Gynecology, and Orthopedic clinics perform limited management of pain in patients with straightforward pain conditions. Modalities used include the administration or prescribing of analgesics/adjutants, the application of ice packs, soft tissue steroid injections, the splinting or casting of fractures, or surgical pain relief procedures that fall within the provider’s privileges. The Physical Therapy service offers the following pain management modalities: Superficial heat; (heat packs, fluidotherapy) Deep heat (Ultrasound); Superficial Cold; Clinical Electrotherapy (Transcutaneous Electrical Nerve Stimulation/TENS, Interferential Current, High voltage, Iontophoresis, Electrical Stimulation and Ultrasound combination); Therapeutic Exercise; Joint Mobilization, Lumbar and cervical traction.

10.4 Providers in the Department of Preventive Medicine refer patients with positive pain screens to the Department of Primary Care and the Department of Military Medicine for further pain assessment and management.

10.5 Patients with complex pain management needs that require extensive ongoing education and counseling, complex oral pain regimens, invasive pain management techniques, or other modalities that falls outside the organization's scope - patients who do not respond to standard pain control modalities offered by our providers - are referred to pain management specialists either at military medical centers or to specialists in the TRICARE Network.

10.6 The Department of Anesthesia & Perioperative Services will conduct an initial postoperative pain assessment on an RWBACH OP 261 (Appendix D) and continue to reassess the patient's level of comfort at regular intervals. A pain intensity self report of less than six on a scale of one-ten (one, almost no pain at all and ten, maximum pain) immediately after surgery is the goal for pain control during recovery and prior to discharge from the PACU. Postoperative surgical patients will be managed in accordance with current anesthesia guidelines and PACU discharge criteria.

11. PATIENT AND FAMILY EDUCATION:

11.1 At the site of care, providers and registered/licensed nursing staff share a responsibility to teach patients and his/her family/significant other(s) that pain management is part of their treatment. Information about pain and pharmacologic and non-pharmacologic pain management tools will be available in pamphlet form to all patients (see RWBAHC Pain Management Pamphlet). Healthcare providers and nursing staff will consider personal, cultural, spiritual and ethnic beliefs, communicating to patients and families the importance of pain management.

11.2 Education content includes, but is not limited to:

11.2.1 Types of pain the patient actually or potentially experience;

11.2.2 Pain control mechanisms available and/or that have been employed to include non-pharmacological therapy: exercise programs, acupuncture, TENS(Transcutaneous Electrical Nerve Stimulation) therapy, heat/cold massage and physical therapy.

11.2.3 Potential limitations of pain management and treatment;

11.2.4 Potential and/or actual side effects of pain management and treatment;

11.2.5 Determination of the patient's acceptable level of pain.

11.3 Directions and precautions for preparation, self-administration and home use of medications. Side effects or drug interactions should also be discussed.

12. STAFF EDUCATION.

12.1 All clinical staff will receive education regarding pain management as part of their organizational orientation (See Pain Management Presentation and Pain Management Staff Quiz). Clinical staff must also demonstrate initial and annual competence through the organization's Competency Based Orientation system.

13. PERFORMANCE IMPROVEMENT. The Medical Records Review Committee, as needed, will analyze data from a representative sample of reviewed medical records across the organization. Conclusions and recommendations from this committee will be forwarded to the Executive Committee of the Professional Staff (ECOPS) monthly in PDCA format in order to continually assess and improve the organization's pain management responsibilities.

The proponent of this publication is Deputy Commander for Clinical Services. Users are invited to send comments and suggested improvements on DA Form 2028 directly to DCCS, ATTN: MCXJ-DCCS, USA MEDDAC, Ft Huachuca, AZ 85613

FOR THE COMMANDER:

OFFICIAL:

JOHN J. GUARDIA
MAJ,MS
Deputy Commander for
Administration

ROBERT D. LAKE
Information Management Officer

DISTRIBUTION: A

Appendix A
SF 600 Pain Screen

Personal Data - Privacy Act of 1974 (PL 93-579)

HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE/SF600E

| SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION

Date: 25 May 2004@0923 Clinic: MESQUITE TEAM
Provider: ANCELINO,CARLA N Division: BLISS AHC, AZ

Appointment:
23 year old Female with RTN appointment type
Reason:
Date: 25 May 2004@0923

Allergies:
SULFA-DRUGS (rash)
OTHER [WATCH NARCOTICS]

Current Outpatient Medications: Ref Last Filled

...No active outpatient prescriptions...

Current Medications/Supplements:

Temp:____ Pulse:____ Resp:____ B/P:____ Height:____Weight:____

**********Refer to Assessment Information Poster for Guidance**********
Educational issues of concern: No___ Yes___ specify:_____
Nutritional issues of concern: No___ Yes___ specify:_____
Functional issues of concern: No___ Yes___ specify:_____
Psychosocial issues of concern: No___ Yes___ specify:_____
Pain: No___ Yes___ Intensity:___/10 (0 10 scale,refer to poster)

Quality:_____ Location:_____ Duration:_____

Do you use tobacco? ___Yes ___No Want to quit? ___Yes ___No
Cessation material provided? ___Yes ___No

Is your health problem today deployment related? Yes___ No___

Name: TEST,LISA FMP/SSN: 20/000001904 Sex: F PCat: A31
Spon: TEST,LISA Clinic: MESQUITE TEAM
Rank: PRIVATE FIRST CLASS Outpt Rec Rm: RECORDS ROOM OUTPATIENT
Unit: TRAINEES DET USA MEDDAC ME: 520-458-9930 DOB: 10 Jul 1980

APPENDIX B
Screening for PAIN INTENSITY SCALES AUTHORIZED FOR USE
Whaley/Wong Pain Faces and 0-10 Pain Scale (Color)

Children: The adapted 0-10 Wong-Baker Faces pain Scale will be used if the children are able to report their pain. The Post Anesthesia Care Unit will correlate their Wong -Baker Faces Scale with a numeric designation utilizing the 0-10 Numeric Scale Children are presented with face drawings representing the happiest feeling possible to the saddest feeling possible.

Adult: The 0-10 Numeric Scale will be used for adult patients. The number reported by the patient is the "pain score" and will be documented.

Appendix C
MEDCOM FORM 686-R

MEDICAL RECORD - SHORT STAY ASSESSMENT
For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: This assessment is for use with the adult patient whose hospital stay is less than 24 hours. It should be completed by the RN, or other health care personnel according to local policy.

SECTION I: VITAL SIGNS/OTHER INFORMATION

Date: _____ Time: _____ Patient oriented to: ☐ Safety procedures ☐ Call light use ☐ Side rail use ☐ Unit procedures

Temp: _____ ☐ Oral ☐ Rectal ☐ Axillary ☐ Tympanic Pulse: _____ Respirations: _____

BP: _____ Rhythm: _____ Height: _____ Weight: _____

Presenting Complaint: Allergies:

SECTION II: REVIEW OF SYSTEMS

Directions: *A check (✓) in the small box, left column, indicates stated description reflects actual physical findings. An asterisk (*) in the box indicates that a variance exists. A brief explanation of abnormal findings is required, or you may circle the appropriate descriptive terms.*

1. NEUROLOGICAL. Alert and oriented to time, place, self, and situation. Responds appropriately. Communication is adequate to express needs. Pupils equal bilaterally and reactive to light. Grip strength equal. ☐	Lethargic Unresponsive Comatose Agitated Disoriented Aphasic Doesn't speak/understand English
2. CARDIOVASCULAR. Pulse regular, rate within normal range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. No clubbing. No chest discomfort. Capillary refill is ≤ 2 seconds. ☐	Arrhythmia _____ Tachycardia Bradycardia Pitting edema Cyanosis Capillary refill = _____ seconds. Pacemaker (*Type*): _____
3. PULMONARY. Respirations quiet and regular, rate within normal range for age. Depth is regular. No cough or shortness of breath. Lungs clear to auscultation, all lobes. Chest movement is symmetrical. ☐	Cough: Productive/non-productive Hemoptysis Orthopnea Dyspnea Wheezing Rales/rhonchi Night sweats
4. G.I. Oral mucosa moist; no lesions or bleeding gums noted. Dental hygiene adequate. Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies diarrhea, constipation, or rectal bleeding. Denies recurrent laxative use. No change in appetite. ☐	Halitosis Nausea Vomiting Incontinence Diarrhea Constipation Hemorrhoids Rectal bleeding Heartburn Distension Flatus Last BM: _____ Bowel frequency: _____ Ostomy: _____
5. G.U./REPRODUCTIVE. Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual vaginal/penile/breast discharge. No genital lesions; no breast/testicular lumps. No history (hx) of STD exposure/disease. ☐	Hematuria Retention Frequency Incontinence Nocturia Catheter: Foley/External/Supra-pubic Hx of UTI/calculi Pregnant: ☐ Yes ☐ No ☐ Uncertain LMP: _____
6. MUSCULOSKELETAL. Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal ROM without pain. No joint stiffness, swelling/tenderness, weakness, or paresthesia. No hx of DVT or (+) Homan's sign. ☐	Amputation: _____ Assistive devices: _____ Weakness/paralysis: _____ Homan's sign (L) / (R) leg
7. SKIN. Warm, dry, intact. Normal turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist and intact. ☐	Cyanotic Cold Diaphoretic Flushed Pale Jaundiced Poor turgor
8. PSYCHOSOCIAL. Behavior is appropriate to the present situation. Anxiety is controlled or mild and appropriate. Interacts appropriately with others. ☐	Anxious Fretful Tearful Withdrawn Angry Apprehensive
9. SLEEP. Sleep is usually restful; awakes refreshed. ☐	Patient's description of sleep: _____ Assistance needed to fall asleep: _____
10. PAIN. No current complaint of pain/discomfort. No ongoing (chronic) pain problems. ☐	**PAIN ASSESSMENT.** For patients complaining of pain, complete the following: **Intensity of Pain Scale:** (0 = No pain; 10 = Worst pain)
PATIENT IDENTIFICATION *(For typed/written entries note: Name - last, first, middle initial; grade; DOB; hospital/MTF)*	Location(s): _____ Intensity/Description: _____ Onset/Duration: _____ Exacerbated by: _____ Alleviated by: _____

MEDCOM FORM 686-R

SECTION III: EDUCATIONAL ASSESSMENT

Does the patient exhibit a readiness to learn? ☐ Yes ☐ No If "No," explain: _____

What is his/her most effective method of learning? ☐ Reading ☐ Listening ☐ Pictures ☐ Demonstration ☐ One-on-One ☐ Group/classroom instruction

Education/grade level achieved? ☐ 0-8 years ☐ 9-12 years ☐ 13-16 years ☐ 16 + years

TEACHING NEEDS: Identify specific areas for patient/family education. *(Check all that apply)*

☐ Advance directives	☐ Infection control	☐ Respiratory care
☐ Breast/testicular self exam	☐ Isolation precautions	☐ Safety precautions
☐ Community resources	☐ Medical equipment use	☐ Sexual concerns
☐ Drug-food interaction	☐ Medications	☐ Skin care/hygiene/grooming
☐ Elimination	☐ Nutrition/hydration	☐ Stress management
☐ ETOH/tobacco/drug use/abuse	☐ Pain management	☐ Other *(Specify)*: _____
☐ Health promotion	☐ Procedure/treatment	
☐ Illness/diagnosis	☐ Rehabilitation techniques	

Factors which may influence the patient's ability to learn:

☐ Cognitive limitations	☐ Language barrier	☐ Psychological factors
☐ Cultural/religious factors	☐ Motivation	☐ Sensory limitations
☐ None - Patient verbalizes/demonstrates understanding.		☐ Hearing ☐ Speech ☐ Vision

Does the patient want educational materials? ☐ No ☐ Yes *(Specify below)*

COMMENTS: _____

SECTION IV: FUNCTIONAL ASSESSMENT (Bathing, dressing, grooming, toileting, mobility, etc.)

☐ The patient demonstrates no functional limitations.

☐ Problem noted: _____

SECTION V: NUTRITION ASSESSMENT (Weight loss/gain, nausea/vomiting, appetite changes, eating disorder, etc.)

☐ WNL - No problem w/food or fluids. ☐ Special diet/restrictions: _____

☐ Problem noted: _____

SECTION VI: SPIRITUAL AND SOCIAL NEEDS

Is there anything we can do to meet your spiritual or cultural needs while you are in the hospital? ☐ Yes ☐ No

If "Yes," please explain: _____

Do you have other concerns that we can help you with? ☐ Yes ☐ No

If "Yes," please explain: _____

SECTION VII: DISCHARGE PLANNING ASSESSMENT - Based on the data collected, it appears the patient will: *(Check all that apply)*

☐ Have no difficulty returning to home environment - no referrals required.

☐ Require assistance in making transition to home - initiated referral to the following:

☐ Home Health ☐ Social Work ☐ Case Manager ☐ Other: _____

☐ Family/significant other able to care for/meet patient needs.

Discharge is anticipated to: ☐ Home alone ☐ Home w/family ☐ Barracks

OTHER CONTINUITY OF CARE ISSUES: _____

Patient's Advance Directive (Living Will, Durable Power of Attorney for health care) is current and included in the medical record?

☐ N/A ☐ Yes ☐ No If "No," explain: _____

From this initial assessment, note patient problems/needs on MEDCOM Form 687-R (Test), Interdisciplinary Plan of Care and/or MEDCOM Form 691-R (Test), Patient Release/Discharge Instructions.

Assessed by: _____ _____ _____

(Signature) *(Printed Name & Title)* *(Date)*

Appendix D
RWBACH OP 261

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post Anesthesia Care Unit Flow Sheet**	OTSG APPROVED *(Date)*

TIME IN:	SURGICAL PROCEDURE:	Hx:
Anesthesia:		EBL:

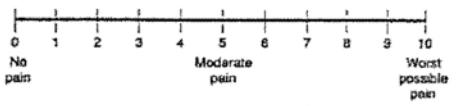
Pre-op BP 20% ——— | INTRAOP MEDS:

TIME							
CRITERIA	ARR	5	10	15	30	45	60
ACTIVITY							
RESP.							
CIRC.							
L.O.C.							
COLOR							
TOTAL							
Sa02							
02							
TEMP							
PULSE							
RESP							
BP							
CMS							
SPINAL LEVEL							

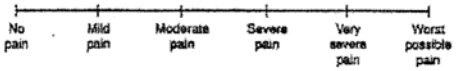
Pain Level:
Time In:
+ 15
+ 30
+ 45
+ 60

IV:		
CARDIAC MONITOR	YES	NO
RHYTHM:		
OXYGEN	YES	NO
AMT: VIA:		
B/P MONITOR	YES	NO
PULSE OX	YES	NO
BRAKE ON	YES	NO
SIDE RAILS UP	YES	NO
CRIB PADDED	YES	NO
WARMER USED	YES	NO

0 - 10 Numeric Pain Intensity Scale*



Simple Descriptive Pain Intensity Scale



MOVE 4 EXTREMITIES ON COMD = 2 MOVE 2 EXTREMITIES ON COMD = 1 MOVE 0 EXTREMITIES ON COMD = 0	DEEP BREATHE / COUGH FREELY = 2 DYSPNEA / LIMITED BREATHING = 1 APNEIC = 0	BP + or - 20% PREANES LEVEL = 2 BP + or - 20-50% PREANES LEVEL = 1 BP + or - 50% PREANES LEVEL = 0	FULLY AWAKE = 2 AROUSABLE ON CALLING = 1 NOT RESPONDING = 0	PINK = 2 PALE, DUSKY, BLOTCHY = 1 CYANOTIC = 0

Level of Comfort (1-10): | Airway: Self maintained / Requires assistance (Oral / Nasal / Endotracheal) Respirations: Spontaneous / Manual

LOC: Awake / Arousable / Unresponsive Follows Commands: Yes No | Surgical limb: yes no Cap refill: Temp: Ice/elevation: yes no

Skin: cool / warm / moist / dry | Dressing: Yes No Type: Location: Appearance:

IV: Fluids and Rate: Site: Appearance

Anesthesia form SF 517 reviewed with:

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700 RWBAHC OP 261, 1 MAR 01

TIME	MEDICATION	AMOUNT	ROUTE	INIT	PATIENT RESPONSE

AT TIME OF DISCHARGE PATIENT'S VITAL SIGNS ARE:					
dressings are dry and intact	YES	NO	NA		
taking fluids without nausea or emesis	YES	NO	NA	NURSES SIGNATURE	INITIALS
alert, oriented to time, place, and person	YES	NO	NA		
standing/ambulatory	YES	NO	NA	NURSES SIGNATURE	INITIALS
has voided	YES	NO	NA		
pain level equal to or less than 5	YES	NO	NA	NURSES SIGNATURE	INITIALS
displaying no detectable post-op problems	YES	NO	NA		
escorted to car in wheelchair by ASPU staff	YES	NO	NA	NURSES SIGNATURE	INITIALS

POST ANESTHESIA NOTE: Patient interviewed. No voiced or obvious anesthesia complications.

ANESTHETIST/ANESTHESIOLOGIST SIGNATURE AND STAMP

Appendix E
2004 JCAHO standards addressing pain management

RI.2.160 Patients have the right to pain management. EP1 – The organization plans, supports, and coordinates activities and resources to ensure that pain is recognized and addressed appropriately and in accordance with the care, treatment, and services provided, including the following: a) assessing for pain; b) educating all relevant providers about assessing and managing pain; c) educating patients and, when appropriate, families about their roles in managing pain and the potential limitations and side effects of pain treatments

PC.6.10 The patient receives education and training specific to the patient's needs as appropriate to the care, treatment, and services provided. EP3 As appropriate to the patient's condition and assessed needs and the organization's scope of services, the patient is educated about the following: Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management.

PC.8.10 When pain is identified, the patient is assessed and treated by the organization or referred for treatment. **EP2** A referral for a comprehensive pain assessment is made or a comprehensive pain assessment is conducted when warranted by the patient's condition. **EP4** Reassessment and follow-up occur according to the criteria developed by the organization or as required by the organization assessing or treating the pain. **EP5** If conducted by the organization, the assessment and measure of pain intensity and quality (for example, pain character, frequency, location, duration, exacerbating and reliving factors) appropriate to the patient's age are recorded. **EP7** When pain is identified; the patient is treated by the organization or referred for treatment

PC 13.40 Patients are monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia. **EP2** Each patient's physiological status, mental status, and pain level are monitored.

PI.1.10 The organization collects data to monitor its performance. **EP3** The organization collects data on the perceptions of care, treatment, and services of patients, including the following…the effectiveness of pain management when applicable.